STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
45 Fremont Street, 21st Floor
San Francisco, California 94105

October 4, 2004 **File No. RH03029740**

MANDATED BENEFITS ANALYSIS REGULATIONS

INITIAL STATEMENT OF REASONS

SUBJECT OF PROPOSED RULEMAKING

The Commissioner proposed the adoption of Title 10, Chapter 5, Subchapter 2, Article 1.3. These regulations require the Insurance Commissioner to assess and collect funds from health insurers, to fund a study to be performed by the University of California regarding the efficacy of certain legislatively mandated benefits. These regulations are required by California Health and Safety Code sections 127760 – 127764.

DESCRIPTION OF THE PUBLIC PROBLEM

California Health and Safety Code Section 127660 became effective as law on January 1, 2002. This statute requires that the University of California prepare an analysis and systematic review of health benefits currently mandated by the Legislature to determine if mandating that health insurers provide these specific health benefits is in the public interest. These legislatively mandated benefits to be reviewed are specified at California Health and Safety Code Section 127660 (c) and include bone marrow testing for prospective donors, infertility treatments, hearing aids, bone density testing and treatment for substance related disorders. .Other legislatively mandated benefits to be studied include such benefits as wigs for patients who have undergone chemotherapy and genetic disease testing.

California Health and Safety Code Section 127662(a) provides that the California Department of Insurance and the Department of Managed Care will provide up to two million dollars [$2,000, 000.00] in to fund the review, by assessing health insurers and health service plans for the costs of the study during the Fiscal Years 2002/3, 2003/4 and 2004/5 and 2005/6. As required by statute the Department of Insurance and the Department of Managed Care met and stipulated to their respective obligations to fund the mandated benefits study. Based on a market share analysis, it was determined that 87.6 percent of the costs of the mandated benefits study were to be borne by health care service plans [under the jurisdiction of the Department of Managed Care] and 12.4 percent of costs were to borne by health insurers [as defined by California Insurance Code 106] under the jurisdiction of the Department of Insurance

Statutory scheme requires that the Department of Insurance assess health insurers to fund the above described study, but does not provide a formula setting forth the computation of each health insurers individual share of the overall assessment. Additionally, the statute does not specify any mechanism for the collection of the assessment from the health insurers.

The specific purpose for each proposed adoption and the rationale for the determination that each adoption is reasonably necessary to carry out the purpose for which it was proposed together with a description of the public problem each adoption is intended to address is set forth below.

Proposed California Code of Regulations section 2218.60(a) - (Adopt)

Proposed California Code of Regulations section 2218.60(a) defines "health insurer" as used in these regulations. The definition set forth provides that a "health insurer" is any disability insurer that issues a policy of "health insurance" as defined in California Insurance Code Section 106. The purpose of this definition is to clearly identify those insurers who are subject to the assessment mandated by California Health and Safety Code Sections 127660-3. The definition was drafted so that it was simple and directly refers to California Insurance Code Section 106 so that the definition could be easily referred to and understood by regulated entities.

Proposed California Code of Regulations section 2218.60(b) - (Adopt)

Proposed California Code of Regulations section 2218.60(b) defines "numbered of covered lives" as the sum of all named insured and their dependents insured by a health insurer. The purpose of this subsection is to define one of the key components of the calculation used to determine the amount of the fee that each health insurer will be assessed under these regulations. The definition will provide needed clarity regarding a term used throughout the regulations. In determining how to calculate the fee, it was necessary to select data which the Department and the regulated entities either already had in some preexisting format, or data that could be easily obtained. Covered lives is a standard measure used throughout the life health and disability insurance industry and thus "the number of covered lives" was selected for use in these regulations rather than creating a new measuring concept specifically for these regulations.

Proposed California Code of Regulations section 2218.60(c) - (Adopt)

Proposed Section 2218.60(c) defines the term "percent to total ratio "as used in these regulations. The term is defined as the total number of covered lives insured by a health insurer in the State of California divided by the total number of covered lives insured by all health insurers in the State of California, The purpose of this definition is to define one of the key components of the calculation used to determine the amount of the fee that each health insurer will be assessed. The definition will provide needed clarity regarding a term used throughout the regulations.

Proposed California Code of Regulations section 2218.60(d) - (Adopt)

Proposed Section 2218.60(d) defines the term "total need" as the dollar amount that the Department of Insurance stipulated to fund the study of mandated benefits required by California Health and Safety Code Section 127660-3. The purpose of this definition is to clearly delineate one of the key components of the calculation used to determine the amount of the fee that each health insurer will be assessed. The proposed subsection is necessary as the definition will provide needed clarity regarding a term used throughout the regulations. This amount of total need varies by fiscal year, and thus a fixed value could not be set forth.

Proposed California Code of Regulations section 2218.61(a) - (Adopt)

Proposed Section 2218.61(a) requires that every health insurer shall be assessed and shall pay a fee in the amount described for each policy of written in California for insurance or group disability insurance that provides hospital, medical or surgical benefits. This subsection sets forth in a clear fashion that each insurer will be assessed. It clearly informs insurers of their obligation under this law. This subsection is necessary as it provides needed clarity, and specificity as it advises insurers of the fee that they will be assessed.

Proposed California Code of Regulations section 2218.61(b) - (Adopt)

Proposed Section 2218.61(b) provides that the Commissioner shall calculate and levy an assessment of all health insurers equal to the appropriation contained in the State Budget for the administrative and operational costs of administering the statutes set forth at California Health and Safety Code Section 127760et.seq. plus or minus amounts the Commissioner deems necessary as a contingency against unanticipated fluctuations in expenditures and revenues as well as amounts the Commissioner deems necessary to correct for over or under collections in previous years. The purpose of this subsection is to inform the regulated entities that the Commissioner must calculate and levy an assessment on these regulated entities and to set forth clearly the various adjustments that the Commissioner may make to ensure that the statute is effectively administered. This provides additional information to the regulated entities of their obligation and how and why it may vary from year to year.

Proposed California Code of Regulations section 2218.61(c) - (Adopt)

Proposed Section 2218.61(c) authorizes the Commissioner to adjust the amount set forth in (b) above by excluding assessments for fees that are impractical to collect or are so small that the costs of assessment or collection of the fee exceed the amount of the total fee assessed. The purpose of this subsection is to prescribe the manner in which the Commissioner may act to ensure that assessments required by the enabling statute are too made. This subsection is necessary as it provides the specificity needed so that the Commissioner can discharge his duty to collect the required assessment, implement the

statute and ensures that the Department's fiscal resources are not unnecessarily depleted by this process.

Proposed California Code of Regulations section 2218.62(a) - (Adopt)

Proposed Section 2218.62 (a) provides that the formula for calculating the fee assessed from each health insurer shall be based on the number of covered lives insured by each health insurer in the calendar year preceding the first day of the fiscal year in which the assessment is made calculated by annual line of insurance. The purpose of this section is to specify the component parts of the calculation to be used to determine the amount of the fee assessed from each individual health insurer The enabling statute does not provide a specific formula for the calculation. This subsection provides one of the specific component parts of the formula and thereby provides necessary specificity that enables insurers to interpret, understand and to fulfill the obligations imposed upon them by the enabling statute.

Proposed California Code of Regulations section 2218.62(b) - (Adopt)

Proposed California Code of Regulations section 2218.62(b) sets forth the formula for calculating the fee to be assessed. This subsection of the regulations sets forth the following formula: The aggregate of all covered lives insured by an insurer will be used to determine a percent to total ratio for each insurer. The subsection goes on to provide that percent to total ratio will be multiplied by the total need [defined in subsection 2218.62 (d)] to calculate the amount of the fee to be assessed each health insurer. This subsection is necessary to implement, interpret and make specific the enabling statute as this statute does not specify any formula for the calculation of the fee to be assessed.

Proposed California Code of Regulations section 2218.63(a) - (Adopt)

Proposed California Code of Regulations section 2218.63(a) provides that the Department shall issue an invoice to each health insurer setting forth the amount of assessment owed. The purpose of this subsection is to specify the procedure to be followed by the Department in collecting the fee. This subsection is reasonably necessary to implement, interpret and make specific the enabling statute as this statute does not specify any procedure to be followed by the Department when assessing or collecting the fee required by statute.

Proposed California Code of Regulations section 2218.63(b) - (Adopt)

Proposed California Code of Regulations section 2218.63 (b) provides that invoices issued pursuant to these regulations shall assess a fee calculated in the manner described in 2218.62 (a) from each health insurer for the Fiscal Years 2002-3, 2003-4; 2004-5 and 2005-6. This subsection further provides that the Department shall issue one single invoice for the Fiscal Year 2002-3 and 2003-4 and separate invoices will be issued for each of the Fiscal Year 2004-5 and 2005-6. The purpose of this subsection is to specify the procedure to be followed by the Department in calculating and collecting the

specified fee. This subsection is necessary to implement, interpret and make specific the enabling statute as this statute does not specify any procedure to be followed by the Department of Insurance in collecting the fee required by the enabling statute. Further, the issuance of an invoice establishes a procedure that inures to the benefit of both the insurer and the Department in that it serves as notice of the assessment for insurers who may have constructive notice of the obligation to pay the assessment, but no actual knowledge or notice. Additionally, the requirement of the various invoices allows both the insurer and Department to accurately and easily capture data.

Proposed California Code of Regulations section 2218.63(c) - (Adopt)

Proposed California Code of Regulations section 2218.63 (c) provides that invoices issued pursuant to these regulations shall be considered delinquent if the total amount invoiced is not received within 45 days of the date that the invoice is issued. The purpose of this subsection is to specify the procedure to be followed by the Department in collecting the fee. This subsection is necessary to implement, interpret and make specific the enabling statute as this statute does not specify any procedure to be followed by the Department of Insurance in collecting the fee required by the enabling statute. The forty five day period allotted for payment of the amount invoiced was selected because it provides the regulated entity with an adequate time period within which to process and transmit the required payment and it also gives the Department a reasonable and feasible amount of time within which to collect the required fees that is not overly burdensome on the Department.

Proposed California Code of Regulations section 2238.63(d) - (Adopt)

Proposed California Code of Regulations section 2238.63 (d) provides that fees assessed and collected pursuant to these regulations shall be deposited in the Health Care Benefits Fund for the sole purpose of collecting and disbursing funds for the administrative and operational costs arising from the provisions of Chapter 7, Part 2 of Division 107 commencing with Section 1276600. The purpose of this subsection is to clarify that the fee assessment required by the enabling statute will be used for only the specified purpose (funding the mandated benefit study). The regulated companies will benefit from this information as it will make the statute and the assessment process more understandable and thereby enhance overall compliance.

PRE NOTICE DISCUSSIONS

The Commissioner engaged in discussions with the Department of Managed Health Care and determined the respective percentage shares to be used in determining the amount of assessments. [For more detailed analysis of these discussions see Statement of The Public Problem.]

IDENTIFICATION OF STUDIES

The Commissioner has relied upon the memorandum, dated September 30, 2004 prepared by Leo Lara, Sr. to Debra A. Chaum setting forth the methodology and assumptions used by the Department in determining the potential impact on insurers and insured

SPECIFIC TECHNOLOGIES OR EQUIPMENT

Adoption of this regulation as proposed would not mandate the use of specific technologies or equipment.

ALTERNATIVES

The Commissioner must determine that no reasonable alternative exists to carry out the purpose for which the regulations are proposed.

From: Lara, Leo
Sent: Thursday, September 30, 2004 10:38 AM
To: Chaum, Debra
Cc: Gentile, Benjamin
Subject: AB 1996 - Amount Per Covered Lives Estimate
Importance: High

Good morning, Debra.

Per our conversation yesterday, the purpose of this e-mail is to provide you with an estimate of the cost per covered lives (for CDI's licensees) resulting from AB 1996. The estimates are for FY2003-2004 and FY 2004-2005

What follows is a brief description of the methodology used to develop our estimate, as well as, the AB 1996 Amount Per Covered Lives Estimate.

METHODOLOGY

From what I understand about Assembly Bill 1996, HSCS 127662 establishes the Health Care Benefits Fund and allows the CDI to assess health insurers (as defined in CIC 106). For the AB 1996 Amount Per Covered Lives Estimate, health insurance is defined using **CIC 106(b)** - "individual or group disability insurance policy that provides coverage for hospital, medical or surgical benefits."

In developing the estimate, we used the following formula:

CDI's Share of AB1996* ÷ **Hospital, Medical & Surgical Covered Lives**

- CDI's Share of AB1996 - These figures are developed by the DMHC. We obtained our data from Tonya Harrison (CDI, Budget Office)
- Hospital, Medical & Surgical Covered Lives - These figures were obtained via the 2003 & 2004 Accident & Health Covered Lives Data Call. This is a study conducted annually by the Statistical Analysis Division. Since CIC 106(b) defines health insurance as "individual or group disability insurance policy that provides coverage for hospital, medical or surgical benefits," we used the total covered lives for Hospital, Medical & Surgical (HMSR) reimbursement policies.

AB 1996 AMOUNT PER COVERED LIVES ESTIMATE*

FY 2003-2004 Estimate:

$247,440 (CDI's share of AB 1996, FY 03-04) ÷ 1,380,066 (2003 AHCL, HMSR) = $ .18 per covered lives

FY 2004-2005 Estimate:

$377,315 (CDI's share of AB 1996, FY 04-05) ÷ 1,434,843 (2004 AHCL, HMSR) = $ .26 per covered lives

*** (An Important Note About CDI's Share of AB 1996)** - These estimates are for CDI licensees and do not apply to DMHC HMO's. It is important to note that DMHC develops the FY03-04 and FY04-05 amounts using a standard 12% ratio for the CDI's annual share. I am unfamiliar with the DMHC's methodology used in calculating the CDI's share amount or the 12% ratio.

If you have any questions, please contact me at the number listed below or via e-mail reply to this message. Thanks for your attention & have a great day.

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